

**DATE: August 19, 1998**

**FROM:** Director, Chronic Care Purchasing Policy Group, CHPP  
Acting Director, Disabled and Elderly Health Programs Group, CMSO  
Deputy Director, OCSQ

**SUBJECT:** Medicare Hospice - Interdisciplinary Team

**TO:** Associate Regional Administrators, DMSO  
Associate Regional Administrators, DHPP/DBHPP

### **Purpose**

This memorandum is to address recent questions and concerns raised by the staff of the San Francisco regional office regarding the use of multiple interdisciplinary groups (IDGs) within a hospice. The purpose is to discuss these concerns in the context of current law, regulations, and survey process

### **Background**

In recent years we have seen individual hospices grow in both size and character. Today it is not unusual to find large hospice organizations serving a large patient population throughout significant geographic areas, as opposed to the small community based hospices that were anticipated to be the norm when the Medicare hospice benefit first began. As such, these large hospices often have established more than one IDG to care for their patients.

We have always recognized the fact that the size of the hospice and the particular patient census can make more than one IDG advisable. However, it is our understanding that recent hospice surveys have uncovered some concerns about relaxing the interdisciplinary approach to care that is the cornerstone of the Medicare hospice benefit. For example, surveys have found that hospices are using rotating "on-call" physicians, who do not manage or supervise the care of patients, as the physician member of the IDG assigned to review and update plans of care. Hospices have also been found to use IDGs where membership appears to fluctuate by design. Two fundamental issues have surfaced as a result of recent discussions:

- First is our expectation for a continuous, identifiable, relationship between a hospice patient and an IDG.
- Second is how we expect a hospice to handle the demands of the day-to-day flow of changes in physician orders for patient care plans.

### **Continuity Between Hospice IDG and Patient**

42 CFR 418.68 recognizes that hospices may have more than one IDG overseeing the care of the hospice's patients. Albeit, there is nothing explicit in the law or regulations that would imply that the roles and responsibilities of the IDG would differ when a hospice utilizes multiple IDGs for patient care. The hospice must designate, in advance, a specific IDG that will be responsible for establishing the

when the hospice utilizes more than one IDG. These policies should address the responsibility of the hospice to ensure that each patient receives care from an assigned IDG that works together to identify and meet the physical, social, emotional, and spiritual needs of the hospice patient/family facing terminal illness and bereavement.

Surveyors should see evidence during a survey that each patient/family has been assigned to a specific and identifiable IDG that is working together to meet the needs of the patient.

The hospice IDG(s) is responsible for participation in the establishment of the patient's plan of care, the provision or supervision of hospice care and services, and periodic review and updating of the plan of care. The IDG is also responsible for managing the patient's discomfort and symptom relief. Implicit in this concept is the idea that the members of the group will have stable relationships among themselves in reference to the patient and thus provide interdisciplinary care that has continuity. As mentioned above, we recognize that it may be necessary for some hospices to utilize multiple IDGs for patient care. One common example is utilizing specific IDGs to cover the patient population within a specific geographic area. Nevertheless, we would expect the relationship between the IDG and the patient to be a continuous and identifiable one. We do recognize that the actual membership of the IDG may change from time to time due to unusual occurrences (e.g., staff turnover); however, we would not expect a patient to be treated by an IDG whose membership is temporary by design.

Hospices may involve other members of the care team in the IDG's activities; but it is the IDG that is responsible for conducting an ongoing assessment of each patient's/family needs and developing and updating, as needed, a plan of care which reflects this assessment. It is also the IDG that is responsible for the provision or supervision of hospice care and services. "Supervision" of care may be accomplished by conferences, evaluations, discussions, and general oversight, as well as by direct over-the-shoulder observations.

### **Day-to-Day Changes in the Plan of Care**

As you recall from a memo dated June 27, 1997, hospices participating in the Medicare program must use an interdisciplinary approach to assessing the medical, physical, social, emotional and spiritual needs of the patient and continue this approach while caring for the patient and family. The regulations at 42 CFR 418.58 require the hospice to have a written plan of care established by the attending physician, the medical director or physician designee and interdisciplinary group (IDG) prior to providing care. This plan of care must include an assessment of the individual's needs, identification of the services to be provided including the management of pain and other uncomfortable symptoms and must state in detail the scope and frequency of services needed to meet the patient's and family needs. A range of services is acceptable as long as it continues to meet the identified needs of the patient/family. The regulations at 42 CFR 418.58 also require that the plan of care be reviewed and updated, at intervals specified in the plan, by the attending physician, the medical director or physician designee and the IDG. We would expect these reviews and updates to be completed in such a way as to ensure that the plan

of care continues to reflect the patient's condition and to meet the needs of the patient and his/her family. An "on-call" physician who has not been assigned to a particular IDG may assist in reviewing and updating plans of care but would not take the place of the hospice physician assigned to this particular IDG. The hospice should assure that the "on-call" physician is in agreement with the hospice's philosophy on pain control and symptom management.

The hospice physician and IDG are responsible for establishing a system of communication and integration of services that ensures that the plan of care continues to be reviewed and updated to serve the dying person and his/her family well. There is nothing in the statute or regulation which requires the IDG to meet every time a change is necessary to the plan of care. There are, however, statutory and regulatory requirements for an IDG approach to caring for the hospice patient. What is critical to hospice care is that the IDG identify through its ongoing assessment when a change is needed to care for the patient and assure that the patient/family receive the care and services necessitated by the change. The hospice must then follow its own system of communication which has been established by the IDG to ensure that the plan is reviewed and updated by the IDG. For example, the hospice IDG must agree to communicate at appropriate intervals specified in the plan of care. If a nurse assesses a patient's pain on a Thursday evening and determines that the medication is not effective, the nurse and the physician can make a change to the medication and plan of care and implement this change immediately. However, the nurse and physician must communicate this change in the plan of care to the other IDG members in a timely manner so that the patient receives the benefit of a full interdisciplinary assessment regarding his/her change in condition. In this way the patient receives the benefit of the entire IDG's assessment of the patient's needs which would include the nurse and physician's assessment and interventions regarding the pain management issue. The IDG can then revise the plan of care as appropriate to address the change in the patient's condition. We do agree that in the ideal, the plan of care should not only address the patient/family's current condition and identify the appropriate interventions, but also address possible changes in condition and identify approaches for handling those changes as well.

## **Conclusion**

We expect hospices to have policies and procedures in place that are in agreement with the IDG requirements at 42 CFR 418.68 and we expect that they adhere to these requirements if they wish to remain in the Medicare program. The hospice regulations require an interdisciplinary approach to the provision of care and services. The IDG should not function in a multi-disciplinary format where each discipline simply makes decisions for necessary care within a particular discipline. The IDG should function in an interdisciplinary format where each discipline gives input from the viewpoint of their discipline for all issues facing a patient.

Please feel free to contact Carol Blackford, (CHPP) at (410) 786-5909 or Beverly Cullen, (CMSO) at (410) 786-6784, or Lynn Merritt-Nixon, (OCSQ) at (410) 786-4652 with any additional questions, comments, or concerns.

<i>/s/</i>	<i>/s/</i>	<i>/s/</i>
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cc: RAs, RO 1-X

Revised: 5/7/98  
5/19/98